

Executive Summary

Quality Rating Systems (QRS) are currently operating, under development or being piloted in over 25 states or local areas. As the QRS model becomes integrated into the landscape of child care and education service delivery, policy and the decisions parents make about child care across the United States, there is an increasing need for descriptive and comparative information about QRS implementation and evaluation.

Acknowledging this need, the Office of Planning, Research and Evaluation (OPRE) in the Administration for Children and Families (ACF), U.S. Department of Health and Human Services (DHHS) is supporting a project called the Child Care Quality Rating System Assessment (QRS Assessment).¹ The goal of the QRS Assessment is to provide information, analysis and resources about QRS for states and other key stakeholders.

The Compendium of Quality Rating Systems and Evaluations² is the first product of the QRS Assessment and is intended to serve as a rich resource for the other tasks in the QRS Assessment which include a multi case in depth study, secondary analysis of existing QRS data, an analytic paper, and a toolkit for designing research and evaluation of QRS. The Compendium is intended to be a source of detailed information about QRS that can be compared, analyzed and used to generate hypotheses or research questions that can be addressed in the other QRS Assessment tasks. Work on the QRS Assessment is informed by an Expert Panel convened for the project that provides guidance and input on the primary tasks and products.

The Compendium contains two different types of information about QRS. The first section presents descriptive information obtained by examining 26 QRS nationwide. Cross-QRS matrices are included to simplify the information and to facilitate a review across states. The second section contains individual profiles of the 26 QRS in which data were collected for the QRS Assessment. Data were collected from July to October, 2009 and were finalized in early 2010.

Purpose

The purpose of the Compendium is to provide definitions, description, and an analytic framework for assessing the critical elements of QRS and QRS evaluations. The Compendium highlights programmatic and evaluation elements and provides matrices to facilitate comparison of these elements. The Compendium also offers an analytic assessment of certain QRS elements. This assessment is accomplished through a comprehensive review of the information gathered and articulation of key distinctions of QRS components. This analysis can facilitate selection of QRS for the in-depth study and will be useful in the development of hypotheses for the analytic paper in the QRS

¹ Mathematica Policy Research, Inc. (MPR) is conducting the QRS Assessment in partnership with Child Trends and Christian and Tvedt Consulting.

² For simplicity, the Compendium on Quality Rating Systems and Evaluations is referred to in this document as “the Compendium”.

Assessment. It also can provide users of the Compendium with a framework for examining their own system or certain provisions across systems.

Selection of QRS

Selection criteria were used to identify Quality Rating Systems for inclusion in the Compendium. Exhibit ES.1 lists the 26 QRS that are included in the Compendium (categorized by length of implementation). The list includes both statewide QRS and pilot QRS in select geographical areas.³

Exhibit ES.1. Quality Rating Systems Included in the Compendium

| Implementing QRS for More Than Five Years (began prior to 2004) | |
|---|---|
| Colorado | Qualistar Rating System (2000) |
| District of Columbia | Going for the Gold (2000) |
| Florida (Palm Beach County)^ | Quality Counts (2000) |
| Indiana | Paths to QUALITY (2001) |
| Kentucky | Stars for Kids Now (2001) |
| Maryland | Maryland Child Care Tiered Reimbursement Program (2001) |
| Missouri ^a | Missouri Quality Rating System (2003) |
| New Mexico | Look for the Stars (1999) |
| North Carolina | North Carolina Star Rated License System (1999) |
| Oklahoma | Reaching for the Stars (1998) |
| Pennsylvania | Keystone STARS (2002) |
| Tennessee | Star-Quality Child Care Program (2001) |
| Vermont | Step Ahead Recognition System-STARS (2003) |
| Implementing QRS for Three to Five Years (began between 2004 and 2006) | |
| Iowa | Iowa Quality Rating System (2006) |
| Mississippi* | Mississippi Child Care Quality Step System Pilot (2006) |
| New Hampshire | New Hampshire Quality Rating System (2006) |
| Ohio | Step Up to Quality (2006) |
| Oregon | Child Care Quality Indicators Project (2006) |
| Implementing QRS for Two Years or Less (beginning 2007 or later) | |
| California (Los Angeles) | Steps to Excellence Project (STEP) (2007) |
| Delaware | Delaware Stars for Early Success (2007) |
| Florida (Miami-Dade)^ | Quality Counts (2008) |
| Illinois | Quality Counts (2007) |
| Louisiana | Quality Start Child Care Rating System(2007) |
| Maine | Quality for ME (2007) |
| Minnesota (5 pilot areas)* | Parent Aware (2007) |
| Virginia (15 pilot communities)* | Star Quality Initiative (2007) |

³ One statewide QRS, Montana, declined to provide information for the Compendium because the QRS in Montana was undergoing a major revision during the time of data collection

*Indicates a current pilot. ^Two Florida QRS were selected for inclusions in the Compendium.
^The Missouri pilot is on hold as of October, 2009 due to lack of funding.

Data Collection

The data elements for the Compendium were selected based on the QRS Assessment Team's knowledge of critical QRS dimensions, a review of the literature, and input from the Expert Panel convened for the project. Data elements included items in the following categories: QRS program details; administration details; funding sources; goals; program eligibility; application process; quality standards; rating structure and process; use of observational measurement tools; quality improvement process; financial incentives and supports; linkages to standards, monitoring systems and services; outreach to parents, programs and the public; and evaluation. A data collection template was created to facilitate data collection.

Data were collected using a staged approach. First, existing data sources were used to conduct a scan of information. These sources included compilations of QRS information collected by the National Child Care Information Center and other organizations as well as information from QRS websites. Data elements for which no information was found were highlighted to facilitate the next stage of data collection.

For the second stage of collection, researchers contacted QRS informants in each state to assist with completion of the template. An email was sent to the state child care administrator in each state for identification of a QRS informant who could participate in a phone interview with research staff. The phone interviews were usually conducted with state child care administrators along with other QRS staff and were used to fill in any gaps that existed in the data collection template for each QRS. Interviews were individualized so that respondents were asked only about the items for which the research team had no information.

Data were reviewed and entered into a database. Queries were used to build tables for the Compendium and to build individual profiles of the 26 QRS.

Description of QRS Included in the Compendium

Pilot Phase and Date of Full Implementation

- Of the 26 QRS, four are currently in the pilot phase⁴, 11 have already completed the pilot phase and launched the program, and 11 did not ever include a pilot phase.
- Ten QRS were launched between 1998 and 2001; four were launched between 2002 and 2005; and 12 QRS have been launched since 2006.

⁴ As of October 2009, Missouri is not actively operating the QRS pilot due to lack of funding.

Service Area of QRS in the Compendium

- Nineteen QRS are statewide: Colorado, Delaware, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Mississippi, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, and Vermont.
- Three QRS are county-based including Los Angeles, California - a pilot - and two Florida counties: Miami-Dade and Palm Beach.
- Four QRS use some other specification to determine inclusion in the QRS. In Washington, DC, the QRS service area includes the entire District of Columbia. In Minnesota, the pilot service area is marked by counties as well as city limits and a suburban school district. In Virginia, the pilot service area is made up of 15 “communities”, each encompassing cities and counties. In Missouri, counties can participate if they have funding available.

Eligible Programs

- Child care centers are eligible to participate in all 26 QRS examined. Head Start and Early Head Start programs (24) and licensed family child care homes (23) are also eligible in a majority of QRS. Pre-kindergarten or other comprehensive early childhood programs are eligible to participate in 18 QRS, and school-aged programs are eligible in 16 QRS. Legally unlicensed/license exempt home-based programs are eligible to participate in Florida (Miami-Dade), Illinois and New Mexico.

Voluntary Participation

- Most QRS (20 of 26) report that participation is voluntary. The remaining six states have components of their QRS that are mandatory and components that are voluntary. For example in Oregon, indicator data are collected on all licensed programs, but release of information to the public is voluntary. North Carolina, New Mexico and Oklahoma have mandatory rated licenses. This means that the rating system is incorporated into the licensing process. Programs meeting licensing regulations receive 1 star on the rated license. Similarly in Tennessee, all licensed programs receive a “report card” assessment, but participation in the QRS is voluntary. In Maine, programs serving children who receive subsidies are required to participate in the QRS, but others are not.

Programs in the QRS

- The density of programs in a QRS can be calculated by examining the percentage of eligible programs that participate in the QRS. Nearly half of the QRS (12) examined in the Compendium have a density of 30% or less, and 3 have less than 10% program density.

- QRS with mandatory participation at the first level of the system have much higher densities of participating programs (60% or greater). With the exception of Oregon, the QRS with higher densities of participating programs are also those that were launched earlier than other QRS (1998 to 2002).
- The distribution of programs across the rating levels in QRS is another important facet to examine. Fourteen QRS have less than 25% of their programs rated at the top one or two levels. Six have between 25 and 49% of their programs rated at the top one or two levels. Eight have more than half of the programs rated at the top one or two levels.⁵ It is important to note that the 14 QRS with a smaller percentage of programs rated at the top one or two levels are primarily building block systems (or combination systems). It appears that a building block system provides a higher threshold for receiving a rating at the top one or two levels of the QRS.

Administration and Partners

- Twenty-one QRS reported that the lead agency was a state agency such as the Department of Human Services or the Department of Education. California and Florida, Miami-Dade reported that the administrative agency was a local or county agency. Colorado and Missouri QRS are administered by a non-profit agency.
- A variety of partnering agencies were described by QRS Administrators. These include: state agencies, resource and referral agencies, community colleges, universities, or other non-profit organizations. Twenty QRS reported partnering with at least one university. Nine QRS reported a partnership with a community college. Twenty QRS had resource and referral agencies as partners. Twelve QRS partnered with a state agency to perform a variety of functions, and 16 QRS reported partnering with a non-profit organization.
- Common functions of QRS partners include: managing communication and information dissemination, providing support in navigating the QRS, providing technical assistance or quality improvement services, coordinating trainings, providing financial incentives, collecting/validating information to assign rating, evaluation, conducting observations, and data management.

Overview of the Rating Process

- The designs or rating structures used in QRS typically use one of three approaches: building blocks, points, or some combination of the two. In a building block design, all of the standards in one level must be met before moving

⁵ Note that some QRS were counted more than once if they had rating data available for different types of care settings.

on to the next higher level. In a points system, points are earned for each standard and are then added together. Each rating level represents a range of possible total scores.

- Thirteen QRS use building blocks, and five use levels or points. Six QRS use a combination or hybrid approach which incorporates elements of both. . For example, in Florida, Miami-Dade, a points system is used but programs must also meet all of the requirements of one level before they can move on to the next higher level. Two QRS do not fit into the traditional rating structures. In New Hampshire, the QRS does not use ratings. Instead, there are two tiers above licensing (Licensed Plus or Accreditation), and programs must meet certain standards to reach that level. Oregon collects information on quality indicators but does not assign ratings in their system.
- The levels in the system provide the steps for programs to achieve. The most common number of levels in a QRS rating structure is five (13 QRS). Eight QRS use a 4-level structure, four use a 3-level structure, and New Hampshire uses two tiers beyond licensing (one indicating that criteria have been met beyond licensing and one that recognizes accreditation as a step above licensing). Oregon does not use a traditional rating structure. Note that Illinois is counted in two categories because licensed programs use a 4-level structure and licensed-exempt family child care programs use a 3-level structure.
- QRS have incorporated a variety of strategies to facilitate the application process. The majority of QRS (18) offer a preparatory process for providers. Three QRS (Florida, Miami-Dade; Pennsylvania; and Virginia) offer a period for programs to receive a time-limited “pre” rating or a commitment to entering the QRS at a later point. Pennsylvania, for example, offers Start with Stars through which programs can receive financial and technical assistance before receiving a rating. Ten QRS require that programs participate in an orientation session prior to enrollment or as part of the enrollment process. Seven QRS offer an orientation session for the QRS, but it is not required for enrollment in the QRS. Sixteen QRS require or recommend that a self-assessment tool be completed
- The majority of QRS (20) provide a rating to a program within the first three months or within three to six months after receiving an application. Two QRS take 9 months to 1 year after application to provide a rating, and two QRS provide the rating after more than 1 year has elapsed since application.⁶

Quality Standards

- Certain quality categories for child care centers are included in the majority of QRS (20 or more). These include: licensing compliance (26), environment (24),

⁶ Information was not available or applicable in two states.

staff qualifications (26), family partnership (24), administration and management (23) and accreditation (21). Three categories – curriculum (14) ratio and group size (13) and child assessment (12) – are included in half or just under half of the QRS. The remaining categories are included in fewer than ten of the QRS examined: health and safety (4), cultural and linguistic diversity (8), provisions for children with special needs (9) and community involvement (7).

- A similar picture of standards emerges for family child care: certain quality categories for family child care are included in the majority of QRS (19 or more). These include: licensing compliance (22), environment (21), staff qualifications (22), family partnership (21), and accreditation (19). Administration and management is included in 16 QRS. The remaining categories are included in nine or fewer QRS: curriculum (9), ratio and group size (5) and child assessment (8), health and safety (4), cultural and linguistic diversity (2), provisions for children with special needs (6) and community involvement (6).

Rating Process

- In just over half of the QRS (15), the rating is valid for 1 year. In other QRS, the rating is valid for 2 years (7) or more than 2 years (7). In Kentucky and Oklahoma, the length of time the rating is valid depends on the star level a program is assigned. In Kentucky, A level 1 is valid for 1 year, a level 2 is valid for 2 years, a level 3 is valid for 3 years and a level 4 is valid for 4 years. In Oklahoma, programs with a 1+ star rating are valid for 2 years.
- QRS also have policies outlining events that would trigger a re-rating of a program. The most common event that triggers a re-rating is a licensing violation. Other events or issues that could trigger a re-rating include: new ownership of a program, a change in a center director, a change in location of the program, and high teacher turnover.
- QRS typically have an appeal or grievance process available for programs that are dissatisfied with the rating they receive. The process for filing an appeal or grievance is available on the QRS website or in other documentation that programs receive upon application to the QRS.

Use of Observational Measurement Tools

- The majority of QRS that include an observational measure in their system use one or more scales from the family of Environment Rating Scales (ERS) developed by Harms, Clifford, Cryer and colleagues at the University of North Carolina, Chapel Hill. This set of scales includes the Early Childhood Environment Rating Scale – Revised (ECERS-R; Harms, Clifford & Cryer, 2005), the Family Child Care Environment Rating Scale – Revised (FCCERS-R;

Harms, Cryer & Clifford, 2007) or the Family Day Care Rating Scale (FDCRS, Harms & Clifford, 1989)⁷, the Infant and Toddler Environment Rating Scale – Revised (ITERS-R, Harms, Cryer & Clifford, 2006) and the School-Age Care Environment Rating Scale (SACERS, Harms, Jacobs & Romano, 1995). These scales are designed to assess features of the learning environment such as the materials, activities, routines, provisions for health and safety, and interactions that influence children’s experiences in the setting. Other scales used in QRS include the Classroom Assessment and Scoring System (Pianta, La Paro & Hamre, 2008) that focuses more specifically than the ERS on interactions as well as Early Childhood Environment Rating Scale – Extended (Sylva, Siraj-Blatchford & Taggart, 2006) and the Caregiver Interaction Scale (Arnett, 1989).

- Twenty-three of 26 QRS use the ECERS-R and ITERS-R; 19 QRS use the FCCERS-R (or the FDCRS since some QRS like Kentucky have not yet begun using the revised version), and 13 QRS use the SACERS. A small number of QRS use other tools in addition to the ERS. For example, Minnesota and Virginia use the CLASS in preschool-aged center-based classrooms in addition to the ECERS-R. Missouri uses the ECERS-E in addition to the ECERS-R.

Quality Improvement Process

- The availability of trainings linked to or aligned with the QRS was reported in 24 of the QRS. Twenty-one reported on the content of available trainings. The most commonly reported content was assessment of the environment, followed by language and literacy, business practices, specific curriculum, safety, and social and emotional development. Child assessment content was reported by the fewest number of respondents (9). Several states reported additional content areas in available trainings. Additional content areas included infant/toddler in family child care, adult-child relationships, developmental screenings, observation and assessment, inclusion, and specific trainings for the Program Administration Assessment and the state’s Early Learning Guidelines.
- All 26 QRS reported that some type of onsite assistance is available to programs for quality improvement, and eighteen provided information regarding the content of onsite assistance. Thirteen of these reported that onsite assistance included supporting programs with navigation of the QRS (i.e., assisting with filling out paperwork, explaining the rating process). Other content areas mentioned were implementation of a developmental screening tool, training on early learning guidelines (Indiana), infant/toddler information, staff training, and classroom layout.
- Information was collected on the frequency and length of onsite contact as well as the duration of assistance. QRS Administrators typically reported that all three

⁷ Not all QRS have made the transition from the FDCRS to the FCCERS-R.

aspects of onsite assistance varied depending on the needs of the program seeking quality improvement services and did not provide specific answers about frequency, length and duration.

- Eighteen QRS offer improvement awards to participating programs. In two QRS (Ohio and Pennsylvania), the award amount is provided in a matrix, with amounts differing by quality level, type or size of program, and the density of at-risk children served. Two others (California, LA County and Virginia) provide a standard amount or an upper threshold for grant amounts. The remaining QRS (14) do not specify the grant amount but often note that the improvement grant will align with items included in the programs quality improvement plan.

Incentives

- The majority of QRS offer tiered reimbursement (18 out of 26). In three QRS (Florida, Miami-Dade, Indiana and Minnesota), the tiered bonus is only offered to accredited programs, not to programs meeting lower level standards in the QRS. Seven QRS offer a flat rate increase per subsidized child that varies based on the star level. QRS using this approach typically provide a rate matrix to programs showing the rates they are eligible to receive at different star levels for serving subsidized children. The rate matrices also incorporate differences in rates by type of care, geographical location (county) and age of child. Kentucky includes the density of subsidized children in the program as an additional factor in the rates (with those serving more subsidized children eligible for higher rates). Eight QRS offer a percentage increase or differential that is added to the maximum rate a program is eligible to receive for serving a child receiving child care subsidies. The differentials increase with each quality level. Similar to the flat rate approach, a percentage increase may differ depending on the age of child served and the type of care. At the lower quality levels, the differential tends to be in a range from 3% to 5%. At higher levels, the differential can be from 15% to 25% above the maximum rate.
- Quality awards or bonuses are used in only eleven QRS. Five QRS (Delaware, Indiana, Kentucky, Vermont, and Virginia) offer a one-time merit or achievement payment upon receipt of the rating. These awards are generally modest in size (between \$250 and \$2500), depending on the type of program and the star level of the program. Six QRS (Florida-Miami Dade, Florida-Palm Beach, Iowa, Kentucky, Ohio and Pennsylvania) offer awards to support achievement or maintenance of quality on an annual (or biennial) basis. These awards (with the exception of those offered in Pennsylvania and Ohio, described below) are similar in size to those awarded on a one-time basis.
- Two QRS – Pennsylvania and Ohio – offer substantial awards to programs that serve higher densities of vulnerable or at-risk children. In addition to a base rate provided for being at a particular quality level, Ohio offers a dollar amount per subsidized child served that is factored into an annual payment for a program. In

Pennsylvania, an award amount is available for programs that is based on quality level achieved and density of vulnerable or at-risk children served (either 5-25% density or 26% and above).

- A variety of other financial incentives may be linked to a QRS including scholarships, wage enhancements and retention bonuses. These incentives are directed specifically toward individual staff, either for assisting staff with increasing their educational attainment (through the availability of scholarships such as T.E.A.C.H. Early Childhood[®]) or by providing incentives for staying in their workplace. Because these incentives are directed at individual staff, they typically are available to all practitioners in the state/municipality, not just those in programs that participate in the QRS. The majority of QRS (18) offer access to scholarships, while fewer offer access to wage enhancements (6) or retention bonuses (5).

Outreach and Marketing

- All 26 QRS reported using some method of outreach to providers. Twenty-four QRS also reported outreach to the public and specifically to parents.
- The most common method of outreach to parents is a website (23), followed by the dissemination of written materials by QRS contractors/partners (15). Fewer than half of the QRS provide information in languages other than English (9) or provide assistance to non-English speaking parents (9). Eight QRS use mailings as a means of distribution of QRS information to parents, and some report other methods such as posting information in doctors' offices or other public venues.
- QRS Administrators reported on the percent of the QRS budget that is dedicated to outreach and marketing. Of the 19 QRS that provided information on the marketing budget, 12 reported that they do not have any money in the QRS budget specifically earmarked for marketing/outreach. Indiana reported that they spend \$100,000 per year on marketing, and other QRS reported amounts ranging from < 1% to 10% of the QRS budget spent on marketing (Pennsylvania < 0.5%, New Mexico < 1%, Vermont 1%, Ohio 2%, Iowa 5%, Minnesota 10%).

Linkages

- **Child Care Subsidies.** Two primary linkages between QRS and child care subsidies are evident in the data described in the Compendium, though these linkages are not uniform or equivalent across QRS. First, contingencies are created that link the QRS and the subsidy system. These are provisions such as those in Maine that require programs serving subsidized children to enroll in the QRS, or in Oklahoma which requires that programs meet requirements for the one-plus level to be eligible to contract with the state to serve subsidized children. Second, incentives are available to encourage higher quality programs to serve subsidized children. The majority of QRS (18) have a tiered reimbursement

policy which allows a differential to be added above the maximum reimbursement rate for which a program is eligible.

- **Programs from Different Sectors of Early Childhood Education.** One important linkage being made in QRS is the creation of a common framework for bringing together a variety of early childhood programs including community-based child care programs, Head Start programs and pre-kindergarten programs. Most QRS include a range of programs and have established processes for aligning the quality standards used across different program types. Some QRS such as those in Ohio and Pennsylvania require QRS enrollment as an eligibility criteria for serving as a pre-kindergarten program. More detail is needed to understand the processes that QRS use to support multiple program types and to align the QRS requirements with those of the other programs (such as the Head Start Performance Standards and state-specific criteria for pre-kindergarten programs).
- **Professional Development Systems.** There are multiple possible connection points between QRS and professional development systems (PD Systems). Two are described in the Compendium. The first connection is with the PD system infrastructure. Multiple QRS report that they require enrollment in the PD Registry system in the state, so that demographics, educational qualifications and ongoing training records can be accessible in one place. QRS also incorporate levels on the career lattices in the PD System to assess the qualifications of the workforce in programs enrolling in the QRS. A second connection is with the supports and services provided to help programs meet quality indicators and to improve their quality. The connections here were less defined according to the QRS Administrators that provided information.
- **Standards.** Standards are a foundational element in state early learning systems because they provide consensus definitions of the skills and competencies that practitioners need and the goals for children that programs are striving to achieve. Standards are incorporated into QRS in at least two key areas. A small number of QRS report that they have indicators related to curriculum in which alignment with early learning guidelines is assessed. In addition, QRS require that directors, family child care providers or other staff attend training on early learning guidelines and core competencies to practitioners

Evaluation

- Eighteen of 26 QRS reported that some type of evaluation (conducted internally by an external contractor) either has been or is currently being conducted on the QRS. Of those QRS, 9 reported an ongoing evaluation and 9 reported periodic evaluation(s).
- Seventeen QRS had information available about the research questions asked in the evaluations. The type of questions described most frequently addressed the

quality improvement in programs participating in the QRS (reported by nine QRS).

- Seven QRS reported that their evaluations examined issues regarding the implementation of the system.
- The evaluations in six QRS included the validation of the quality ratings in their research questions. The central question in a validation study is whether the different levels that make up a QRS represent different levels of quality.
- Four QRS evaluations include links between the QRS and child outcomes in their research questions. The evaluations including child outcomes are in process in Minnesota and Virginia and results have been reported in Colorado and Missouri.
- The most commonly reported findings to date describe the QRS or implementation issues and validation of the quality rating (six QRS reported each type). Four QRS (Colorado, Florida-Palm Beach, Indiana and Tennessee) reported findings on program quality improvements over time, and Colorado and Missouri reported on child outcomes.

Next Steps for the QRS Assessment Project

- The framework provided in the Compendium offers constructs and a systematic approach to assessing Quality Rating Systems.
- Further work on the QRS Assessment project will use the information in the Compendium to generate questions for in-depth analysis in a multi-case study.